Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for the following services is shown below.

Cost Sharing	
Provider Type	**Amount**
Independent diagnostic testing facility (IDTF)	$4.00 per visit
Mid-level practitioner	$4.00 per visit
Physician	$4.00 per visit
Podiatry	$4.00 per visit
Public Health Clinic	$1.00 per visit

The following clients are exempt from cost sharing:

- Clients under 21 years of age
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid clients who also have Medicare or another insurance are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

Cost sharing may not be charged for the following services:

- Emergencies (see *Definitions*)
- Family planning
- Hospice
- Independent lab and x-ray services
- Personal assistance services
- Home dialysis attendant services
- Home and community based waiver services
- Non-emergency medical transportation services
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- EPSDT services

A provider cannot deny services to a Medicaid client because the client cannot pay cost sharing fees at the time services are rendered. However, the client's inability to pay cost sharing fees when services are rendered does not lessen the client's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy may be used for Medicaid clients. A provider may sever the relationship with a client who has unpaid cost sharing obligation, as long as a consistent policy is followed with Medicaid and non-Medicaid clients. Once the relationship is severed, with prior notice to the client either verbally or in writing, the provider may refuse to serve the client.

When Clients Have Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

PASSPORT Billing Tips

- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not your client's PASSPORT provider, include the PASSPORT provider's PASSPORT number on the claim.
- For claims questions, contact Provider Relations (see *Key Contacts*).

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. For more information on retroactive eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Place of Service

Place of service must be entered correctly on each line. Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges.

Multiple Visits (E&M Codes) on Same Date

Medicaid generally covers only one visit (or hospital admission) per client per day. When a client requires additional visits on the same day, use a modifier to describe the reason for multiple visits. When a modifier is not appropriate for the situation, attach documentation of medical necessity to the claim, and submit it to the appropriate Department program officer (see *Key Contacts* or the *Program Policy Information* table in the *General Information For Providers manual*).